

PATIENT SAFETY

WINTER 2005

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WINTER 2005

A QUARTERLY NEWSLETTER TO ASSIST THE MILITARY HEALTH SYSTEM IMPROVE PATIENT SAFETY

2004 Patient Safety Awards

Second Annual Presentation at TMA Conference

Five Military Treatment Facilities (MTFs) were recognized for their successful patient safety efforts at the TRICARE Management Conference on January 24, 2005 in Washington, D.C. The Second Annual Patient Safety Awards were presented to the **United States Transportation Command, Scott AFB**, Policy and Procedure; the **55 Medical Group, Offutt AFB**, Team Training; the **US Army Trauma Training Center, Ryder Trauma Center**, Team Training; **Brooke Army Medical Center**, Technology; the **US Naval Hospital Okinawa**, Technology.

The Patient Safety Awards recognize leadership and innovation in quality, safety and commitment to patient care by the MTFs. They are meant to reward successful patient safety efforts, particularly in the development of a culture of safety; to inspire increased patient safety efforts; and to communicate successful strategies throughout the Military Health System.

The Policy and Procedure award is presented to a project or initiative that involves successful system changes or interventions that make the environment of care safer. The US Transportation Command Patient Movement (PM) Patient Safety (PS) Program more than meets this challenging criterion.

US Transportation Command Patient Movement Patient Safety Program

Originally established as the Aeromed-

ical Evacuation (AE) Patient Safety Program, over the past two years the system has been expanded and restructured under a unified Command to include all transportation modes and providers of patient movement, from patient preparation to receiving. Now called the Patient Movement Safety Program (PMSP), the system is extremely complex, involving decision-making from remote locations, multiple handoffs, and often different Service affiliations. Integrating all aspects of patient movement has in itself created a safer environment of care, making it possible to collect and share patient safety information.

To that end, the PMSP has developed a



Photo provided by Vincent Rinehart, TRICARE Management Activity

CAPT Richard Becker, Naval Hospital Okinawa receives the 2004 Patient Safety Award for Technology from Assistant Secretary of Defense William Winkenwerder, Jr. and Navy Surgeon General VADM Don Arthur.

centralized web-based Patient Movement Quality (PMQ) tool to document, capture, and trend, analyze and disseminate information pertaining to patient movement safety events and high interest safety items.

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NATIONAL PATIENT SAFETY AWARENESS WEEK

National Patient Safety Awareness Week will be observed March 6-12, 2005. This year the theme is:

Focus on Patient Safety: Ask, Listen & Learn.

Effective Communication: The Patient Safety Tool of Choice.

Providers: Listen to your patients

Speak in simple terms

Encourage them to be a partner

Patients: Medical information is often difficult to understand

Ask questions until you understand what you need to do

Become a partner with your doctor to manage your health

DoD Urges Support of ASK ME! Campaign

All Military Healthcare System (MHS) facilities are encouraged to participate in this national event by supporting the ASK ME! Campaign, which focuses on effective communication and understanding between patients and healthcare providers.

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Photo provided by Vincent Rinehart, TRICARE Management Activity

Presenting the 2004 Patient Safety Award for Policy and Procedure to BG Thomas Loftus, US Transportation Command and Headquarters Air Mobility Command, Scott AFB are Assistant Secretary of Defense William Winkenwerder, Jr. and Air Force Surgeon General LtGen Peach Taylor.

Patient Safety Awards

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For the first time, actual event and near-miss data is being captured and shared across all Services, MAJCOMS and treatment facilities involved in patient movement. Over 2500 patient movement personnel have been trained to use the PMQ tool since the US Transportation Command (USTC) launched the beta version in April, 2004.

Despite the considerable challenge of introducing this system change during ongoing combat conditions, cooperation has been robust. Local investigations assist in identifying process improvement initiatives, while trend analysis at the Unified Command level identifies and directs policy. A community forum capability encourages information sharing. Feedback is available at the unit and command levels, as well as from Central Command.

The Patient Movement Patient Safety Program is a high-level example of a policy-driven systems change. By integrating all levels of medical entities involved in patient movement and by adopting a centralized web based event reporting tool to identify process improvement initiatives and direct policy changes, the PMSP has made the environment of care safer across the entire Military Healthcare System.

For more information, contact:

lisa.dedecker@hq.transcom.mil.

Successful initiatives in Team Training are systems learning approaches that encourage communication and dynamic interaction between human, technological, and organizational factors in the organization. This year, two team training efforts were recognized: the US Army Trauma Training Center and 55 Medical Group at Offutt AFB.

US Army Trauma Training Center

The Army Trauma Training Center (ATTC), operating at the Ryder Trauma Center in Miami, Florida, created a new program of instruction in trauma team training that incorporates the Tricare Management Activity medical team management curriculum. The result is an intense fourteen day "in the box" trauma team training program that is infused with critical team concepts, team talk, and team development events, all in a robust clinical environment. Units are kept together throughout the rotation in the care of acutely injured patients whose injuries are analogous to those seen on the battlefield. Twenty-member units, including surgeons, anesthesiologists, critical care and emergency nurses, and combat medics, become a team of one that is focused on providing safe, effective care to wounded soldiers, sailors, airmen, and marines.

The ATTC trains military trauma units

for clinical deployment, and every unit has deployed in the Global War on Terrorism within a year of completion of the ATTC rotation. Of the thirty-two units that have rotated at the ATTC since its inception in January 2002, six Forward Surgical Teams and one Combat Support Hospital slice have received the new training program. These units have already applied program results at their affiliated MTFs and in Iraq and Afghanistan.

Retooling trauma training with specific team concepts is seen as crucial to mission success. Units work in hostile, austere environments where actions must be quick and precise; the quality of the teamwork directly correlates with patient outcome. Bringing team training into combat casualty care through the training program at the ATTC exemplifies the energy and commitment that the Army Medical Department brings to its Patient Safety Program.

For more information, see *Patient Safety* newsletter, summer 2004, p. 4, "Army Successes Move To 'Frontlines'"; contact john.armstrong@amedd.army.mil, or go to the ATTC website, www.traumateams.org.

55 Medical Group, Offutt Air Force Base

Medical Team Management (MTM) training has been a part of the patient safety education efforts at the 55 MDG since September, 2002. Vignettes have routinely been used to illustrate problem areas and interventions. MTM class members have responded positively to the vignettes. With enthusiastic Command support, the 55 MDG Patient Safety Team enhanced their MTM training by producing four videotaped vignettes based on events experienced at their facility. Using staff as script writers, actors, make-up artist (moulage team), the Patient Safety Team adapted this familiar team training learning tool to relate to the realities of patient safety at the 55 MDG.

The Patient Safety Team began by reviewing actual event reports, choosing identified situations with which they felt the staff could most identify. They solicited volunteer actors and script writers at key staff meetings and during scheduled patient safety rounds. To ensure a high-quality product, a professional cameraman from the base Audiovisual Services was retained. All four vignettes were taped in one morning to accommodate the staffing schedules of the volunteers and to minimize disruption to on-going operations.

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Patient Safety Awards

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This brand of "reality training" has been a great success. As a training tool, because they depict familiar faces and settings, and are based on actual experiences, the vignettes resonate more convincingly with staff. They have been incorporated into formal MTM training. From an organizational perspective, their connection to reported events makes them of interest to the entire facility, and they are being shown at Commander Calls. The Patient Safety Team plans to monitor the vignettes' direct impact on safety. To date, there have been no new reports of events similar to those depicted on the videos.

The 55 MDG, in merging personal experience with a proven team training tool, has created an exciting new internal dynamic which has reinforced patient safety throughout the entire facility.

For more information, contact sara.meier@offutt.af.mil.

Innovations in product development that assist systems and clinicians in measurably reducing the incidence of error, avoidable

patient injury and associated costs are recognized by the Patient Safety Award for Technology. This category had two outstanding awardees: Brooke Army Medical Center and US Naval Hospital Okinawa.

Brooke Army Medical Center

The DoD Patient Safety Program was pleased to present its own Patient Safety Award for Technology to Brooke Army Medical Center for the MPEG Training Program developed by LTC Danny Jaghab. This program was recognized by the National Quality Forum in October, 2004 when the prestigious John M. Eisenberg Award for Innovation in Patient Safety and Quality was presented to LTC Jaghab at the annual meeting of the Quality Forum.

In preparation for the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) survey at Brooke Army Medical Center in 2003, LTC Jaghab created a distance learning course consisting of thirty-four scripts based on JCAHO patient safety goals and recommendations. These scripts provided comprehensive patient safety training to the entire Brooke staff, and were commended by the JCAHO sur-

veyor as an example of best practices in patient safety training. The scripts are now available on the Patient Safety Website: <https://patientsafety.satx.disa.mil>.

The MPEG Training Program was a labor intensive initiative which required the support of the Command staff at Brooke, as well as the involvement of key hospital leaders, who were asked to provide endorsements for each MPEG segment. The active culture of safety at Brooke Army Medical Center was an essential ingredient in the successful production of this nationally recognized training tool. Acting on its commitment to patient safety, the Medical Center provided both an environment conducive to development and a system open to adopting innovative training processes.

For more information, see *Patient Safety* newsletter, fall 2004, p.1, National Award Presented to Army Major; contact danny.jaghab@apg.amedd.army.mil.

US Naval Hospital Okinawa, Japan

The Maximum Daily Dose (MDD) Project at the US Naval Hospital Okinawa (USNHO) created a warning system within

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Photo Credit

Vignette actors and volunteers from the 55 Medical Group include: Back row: Linda Haring, Maj Jere Pound, Lt Col Anne Heinly, SSgt Daniel Lewis, Sara Meier. Front row: Capt Katheryne Friess, Amn Nick Yankosky, SrA Robert Bolgar, A1C Claudio Avila. Participants not in photo: Mary Jo Hopfensperger, Maj Lou Williams, Maj James Simmons, Capt Gary Smith, 1Lt Oscar Olipane, 1Lt Jessica Castro, 2Lt Susan Morton, TSgt Dawn Hendrickson, TSgt Terry Hunt, SrA Andrew Tyler, A1C Larry Smith, A1C Catherine Siscel, A1C Ray Pia, Wilda Ysusi, Bob Clark, TSgt Stacy Wilson, SSgt Chad Coffelt, and A1C Ryan Reeves.

NEWS FROM THE PATIENT SAFETY CENTER

Feedback and Suggestions Based on Your Reporting

PSC FALL REDUCTION TOOLS

Available Late March 2005

Pamela Copeland, RN, BSN, JD, ARM
Nurse Risk Manager, Patient Safety Center

Three days after discharge following triple bypass surgery, a 45 year old male patient presented to the Emergency Department (ED) complaining of gastro-intestinal pain. Post operative medication included coumadin. The patient had a witnessed fall (nurse was in attendance) while attempting to climb back onto the stretcher (in its highest elevated position) after returning from the bathroom, hitting his head and shoulder. On examination, the provider concluded the patient did not have any obvious injuries. The patient was subsequently admitted for evaluation of his gastro-intestinal pain. The fall incident was not documented nor communicated during report. Over two days the patient complained of a headache for which he received Tylenol. He subsequently became stuporous. A CT Scan revealed a subdural hematoma. While being prepped for an emergency ventriculostomy, the patient had a cardiopulmonary arrest and died.

Falls are the number one harm event reported to the DoD Patient Safety Center (PSC), and the fifth leading cause of accidental deaths in the United States.¹ JCAHO 2005 National Patient Safety Goal (NPSG) #9a mandates that facilities “reduce the risk of

patient harm resulting from falls”. The salient features of this goal include:

- ❖ Assessment
- ❖ Periodic re-assessment
- ❖ Documentation of potential risk associated with the patient’s medical regimen
- ❖ Action to address any identified risk

During a three month period, the PSC reviewed patient fall reduction programs at several military facilities representing all three services, as well as civilian facilities, including the VA. Medical Treatment Facilities (MTFs) are diligently working to enhance their current programs to achieve compliance with the JCAHO mandate. The PSC concluded the fall reduction programs at the military facilities varied.

The PSC is committed to supporting the services as you strive to provide a safe environment which minimizes the risk of falls in your facilities. To this end, we have prepared a series of aides entitled “DoD Patient Fall Reduction Tools”. We have reviewed numerous professional articles and have borrowed portions of materials from innovative, industry-forward fall prevention programs.

We have included these documents in the DoD PSC tools:

SAMPLE POLICY: outlines functional responsibilities of various disciplines having contact with the patient; risk assessment categories; re-assessment recommendations;

STANDING ORDER/PROTOCOL: an efficient method to demonstrate interdisciplinary communication and promote standardization for addressing patients at risk for falls;

INTERVENTIONS: suggests actions for

specified fall risk categories, delineated and displayed in easy to recognize columns;

EDUCATION WORKSHEET: for use with patient and family; appropriate for inpatient and outpatient use;

POST FALL ASSESSMENT FORM: for use after a patient fall to collect detailed information according to categories that provide granularity, a feature promoting in-depth analysis;

MEASUREMENT TIPS: a condensed section of the VA NCPS Falls Toolkit, critical for compiling, analyzing, and measuring patient fall data.²;

POSTER/ BROCHURES: to promote facility/patient/family/visitor awareness of Patient Fall Reduction initiatives.

The PSC recognizes that each MTF has its own culture. These are generic tools, and we encourage you to modify and customize them to fit the particular needs of your own practice and procedures. Facility logos can be added to the forms to convey your individual brand.

These DoD Fall Reduction Tools have been developed for the inpatient setting. We recognize that tools are needed for the ambulatory setting and pediatrics, and development in these areas is underway. Please forward ambulatory and/or pediatric fall program models, comments and recommendations to the PSC, copelandp@afip.osd.mil, or call 301-295-8117.

The paramount objective of this initiative is to reduce patient injuries resulting from falls in all DoD MTFs. Prevention is the key. Patient Safety Officers in our MTFs are vital to this initiative. Under your leadership the critical safety information our tools offer can be spread throughout each facility to the wider multidisciplinary audience of providers and staff. We are pleased to join you in this important undertaking. We thank you for your assistance in our preliminary survey, and we salute you as we begin this focused effort to prevent patient falls and reduce the risk of harm to our patients across the DoD Military Health-care System.

1. Falls and hip fractures. Fact Sheet. Centers for Disease Control and Prevention website. www.cdc.gov/ncipc/factsheets/falls.htm. Accessed January 2005

2. The VA National Center for Patient Safety 2004 Falls Toolkit: Falls Notebook. <http://www.patientsafety.gov/Safety-Topics/fallstoolkit/index.html>. Accessed January 2005

DoD PATIENT FALL REDUCTION TOOLS ROLL-OUT

- ❖ Enhanced Patient Safety Training (January 2005) – Promote the Patient Fall Reduction Tools
- ❖ TRICARE Conference (January 24 – 27, 2005) – Poster sized advertisement announcing “forthcoming” DoD PSC Patient Fall Reduction Tools
- ❖ Final Packets disseminated to PSOs (Late March 2005)
 - ❖ Primary means: electronic print ready PDF for local printing, word document
 - ❖ Limited number of hard copies
 - ❖ Poster/Brochures
- ❖ Pediatric and ambulatory fall reduction tools (April 2005)
- ❖ Video-conference - Overview of tools by PSC staff at request of services
- ❖ Newsletter (Winter 2005) – include Patient Fall Reduction Tools feature
- ❖ Nursing Risk Management 2005 – Patient Fall Reduction article
- ❖ Web Forum/Discussion Boards (May 2005)

NEWS FROM THE PATIENT SAFETY CENTER

Feedback and Suggestions Based on Your Reporting

PREVENT FALLS USING HUMAN FACTORS

Increase Effectiveness of Warnings

Bridget Olson, M.S.

Human Systems Engineer, Patient Safety Center

The use of warnings can provide staff, patients and families with pertinent information to help them avoid the risk of falls. The Patient Safety Center often finds a lack of information, both verbal and written, to be the leading contributing factor in reported events.

Effective warnings may reduce the risk of falls by improving the communication of information. Warnings are already used within the healthcare system. They are placed on wet floors and outside rooms of high-risk fall patients, and are given verbally to patients and families. These warnings alert patients, staff, and visitors to the risk of falling in a certain location or to a specific patient's risk for falls.

Design Better Warnings

Human factors research has been conducted in the area of warning design and evaluation. You can adopt some of the principles, offered below, to create more effective warnings. Keep in mind, however, that to change behavior, it is not enough to simply see a warning; it also must be read, comprehended, and acted upon. Four components are recommended for an effective warning:

- ❖ Signal word - Communicates the level of risk, e.g. DANGER, WARNING, CAUTION, NOTICE (from greatest to lowest risk).
- ❖ Hazard - Identifies the hazard with a complete and brief description.
- ❖ Consequences - Explicitly states what will occur if the warning is ignored.
- ❖ Instructions - Provides directions to avoid or reduce the risk of the hazard.

Based on research, here are some basic guidelines you can apply in designing your warning signs. Grab the attention of your audience through the use of these specific tips:

- ❖ Large, bold, legible letters
- ❖ High contrast

- ❖ Color
- ❖ Borders
- ❖ Pictorial symbols
- ❖ Special effects

Supply all of the necessary information, but keep the wording BRIEF. Use a bulleted format, rather than paragraph form, to maintain attention longer and achieve greater compliance. Position the warning in an appropriate location and reduce any visual clutter around the warning. Place the warning near the source of the hazard, e.g. next to the high-risk fall patient or wet floor, where it is more likely to be effective. Account for the culture within your organization. In facilities abroad and other multicultural facilities, design your warnings using pictorials or multiple languages to communicate the warnings to everyone.

As with any new product or design in

your facility, you should evaluate your warning for effectiveness before you roll it out facility wide. Test your warning during the design phase through feedback from the staff and patients. Pilot the completed warning on the floor to determine how well the above four components have been incorporated.

Warnings alone will not alter staff and patient behavior. They are only one part of a more comprehensive falls campaign that aims to communicate the risk of falls and to improve the sharing of information among staff, patients and families.

ⁱ Sanders, M.S., McCormick, E.J. 1993. *Human Factors in Engineering and Design* (McGraw-Hill, Inc., New York).

ⁱⁱ Wogalter, M.S., Conzola, V.C., Smith-Jackson, T.L. 2002. Research-based guidelines for warning design and evaluation, *Applied Ergonomics*, 33, 219-230

ⁱⁱⁱ Desaulniers, D.R. 1987. Layout, organization and the effectiveness of consumer product warnings, in *Proceedings of the Human Factors Society 31st Annual Meeting* (Human Factors Society, Santa Monica, CA), 56-60.

PATIENT SAFETY REGISTRY SUGGESTIONS

Reduce Falls In and Around Your Facility

Mary Ann Davis, RN, BSN, MSA

Nurse Risk Manager, Patient Safety Center

Information reviewed at the PSC indicates there are certain areas, processes and equipment related to patient falls. While most falls occur in the inpatient setting, falls have also been reported in clinics and areas surrounding the health care facility. We offer the following suggestions for your consideration:

Parking lots are an area of frequent slips and falls.

- ❖ Consider a transport system (e.g.: hospitality carts) from parking lot to facility.
- ❖ Check pavement and sidewalks for irregularities on a weekly basis.

Waiting rooms are noted for children playing and falling.

- ❖ Prominently display posters and brochures to educate parents on risk of falls.
- ❖ As part of arrival check-in, advise parents to watch their children while in the waiting room and examining area.
- ❖ Keep examination stools with wheels in areas inaccessible to patients.

Proper use and maintenance of equipment reduces falls.

- ❖ Attach doors so they do not slam when closing.
- ❖ Reinforce steps with non-slip coverings and ridges.
- ❖ Place non-slip strips on the floor by showers.
- ❖ Refit gurneys with locking wheels.
- ❖ Fit examination tables with side rails.
- ❖ Check sound and light indicators on bed alarm systems at every shift change.
- ❖ Have fall alarm/prevention equipment available and handy for use.

PATIENT SAFETY IN ACTION

Experiences and Suggestions From the Field

The two Army initiatives described in this issue reflect a facility-wide focus on patient safety, and highlight the power of coordinating efforts from the top down.

WRAMC IMPROVES PATIENT IDENTIFICATION

New Armbands Introduced

Walter Reed Army Medical Center (WRAMC) made a major commitment to patient safety in April, 2004 when it adopted a new patient identification/armband system. Dr. Rita L. Svec, Director of the Patient Safety Program at WRAMC, says the support of Command leadership and the willingness of departmental leaders to focus on a facility-wide vision of patient safety made such a significant change possible.

As early as 2001 a team was formed at WRAMC to assess the existing identification system. The armbands in use were perceived to have three major vulnerabilities: if cut off, they could not be replaced immediately, leaving a time-gap where a patient was without identification; labeling laboratory and blood-bank specimens using the armbands required a series of steps, any one of which, if missed, could result in misidentification of the patient; the armbands could not be used for point of care labeling.

Once problems were recognized, finding a new system became the priority. Because patient identification is a critical blood bank issue, emerging systems are marketed in this arena. With the assistance of the Blood Bank supervisor, alternative systems were assessed. The system adopted by WRAMC is already in use at Ft. Hood, and comes with a positive endorsement. The new armbands are durable; they can be immediately replaced at the patient's bedside; and can be used for bedside labeling. Color-coding denotes inpatient, same-day surgery, ER and thus helps clarify often confusing routing issues.

Implementation of the new identification system was a multi-step process. Since patient identification involves nearly every department in the hospital, high level Command backing and facility-wide buy-in were critical to ensure financial and philosophical support necessary for a change of such magnitude. Once support was secured, Dr. Svec and her team began the task of implementing the new system.

Step one was to train over one hundred "super-trainers". Assembling and attaching the new armbands is somewhat more complex than the old because they include a detachable imprint card used for labeling, as well as space for allergy and name alerts. Over two days, two individuals per ward or clinic were trained. This was followed by general staff training — six sessions per day over four days. Simultaneously, supplies and logistics were coordinated so that label guns could be installed and supplies assimilated onto floors and clinics.

On Monday, April 19, 2004 the new system "went live". Patients were given hand-outs alerting them to the change. Beginning at 8:00 am three teams were dispatched to change the armbands; by 2:00 pm the new system was fully implemented.

Post-implementation, the challenge has been to monitor and assess progress. After four months, a formal follow-up, via a staff questionnaire, solicited feedback on the system in general, training, and supply issues. Concerns were noted and adjustments were made based on staff responses. The focus now is on maintaining competency. Armband training has become part of Nursing Education; multiple training opportunities (slide shows, videos, on-site and general training sessions) are being developed; physician providers are being trained. Robust incident reporting promotes analysis of problem areas.

The new armbands will be rolled out to the Emergency Department within the next two months. As the system expands, Dr. Svec reports general satisfaction. Operationally, keys to success are keeping armbands in sufficient supply, training staff to have replacements at the bedside before cutting off existing armbands, and labeling at the bedside. Supporting these staff efforts is the active commitment made by the Command and every department at WRAMC to work together to improve patient safety.

For more information on the patient identification system at WRAMC, contact: rita.svec@na.amedd.army.mil.

LRMC EXPANDS PATIENT SAFETY PROGRAM

Patient Safety Assurance Officers Added

The idea of having Patient Safety Assur-

ance Officers (PSAO) at Landstuhl Regional Medical Center (LRMC) was first introduced in October 2002 by LTC Bennett Stackhouse, then LRMC Patient Safety Chairman. Implementation of the new program began in March 2003. The program is aimed at increasing communication and patient safety awareness by assigning a PSAO to every clinic and section in the Medical Center.

To support the PSAO program, the existing Patient Safety Committee was reorganized to include a core group of eight staff members, with each deputy lane represented. The Committee holds monthly patient safety meetings. At the meetings, problems are identified; champions are recruited to solve problems; resources are mobilized; solutions and concerns are shared and organization-wide patient safety initiatives are discussed and communicated.

Upon implementation of the PSAO program a briefing was held for all PSAOs to discuss their duties and objectives. Each PSAO was provided with a patient safety binder. Briefings have continued to be held on a quarterly basis and are followed up with a patient safety newsletter. Solutions and lessons learned from sentinel events and patient safety reports are communicated back to the PSAOs via the newsletter and assistance visits from the patient safety staff. Between meetings, PSAOs work locally on patient safety issues.

Each clinic or section is represented by a Patient Safety Assurance Officer, who can be a civilian employee, a local national, or a military service member of enlisted or officer rank. Currently, there are sixty-three PSAOs at Landstuhl. The PSAO is the patient safety point of contact for his or her clinic or section, with responsibility for event follow-up and communication of safety solutions and information. To maintain a focus on safety, the PSAO discusses patient safety updates with staff and brings safety issues to staff meetings and unit Performance Improvement minutes.

PSAOs are acknowledged during the quarterly briefings for their outstanding contributions. One PSAO is featured at each briefing to present any improvements or changes made in his or her clinic or section.

Over the past two years the program has continued to grow and improve. PSAOs have been instrumental in solving many patient safety concerns and in assisting with root

PATIENT SAFETY IN ACTION

Experiences and Suggestions From the Field

cause analyses. The diversity of the PSAOs contributes to the success of the program and ensures that patient safety is a responsibility assumed by everyone associated with LRMC.

For more information, contact jo.white@lnd.amedd.army.mil.

PATIENT SAFETY LINKS

Interesting Resources To Explore

Institute for Healthcare Improvement

www.ihi.org

"Reconciling Medications to Avoid Medical Errors"

Explains medication reconciliation, an expected 2006 National Patient Safety Goal.

Archives of Internal Medicine

www.archintermed.com

"Patient-Reported Medication Symptoms in Primary Care"

Vol 165, Jan. 24, 2005, pp. 234-240.

Physicians may reduce duration/severity of ADEs with better communication.

Journal of the American Medical Association

www.jama.com

Vol. 293, No. 1, Jan. 5, 2005

Book Review, pp. 104-105

The Culture of Caregiving: Conflict and Common Ground Among Families, Health Professionals, and Policymakers.

Carol Levine and Thomas H. Murray, Baltimore, Md., Johns Hopkins University Press, 2004.

New England Journal of Medicine

www.nejm.org

Vol. 352, No. 3, January 20, 2005

Book Review, pp. 312-314

Military Medical Ethics

Edited by Thomas E. Beam and Linette R. Sparacino, Washington, D.C., Office of the Surgeon General, Department of the Army, and Borden Institute, 2003.

American Medical News

www.amednews.com

Vol. 48, No.1, Jan. 3-10, 2005

"Patient Safety Laboratories", pp. 5-6

Report on State patient safety programs.

Also see weblink:

<http://www.kff.org/kaiserpolls/7209.cfm>

Kaiser Family Foundation national survey of consumers' experiences with patient safety.

Patient Safety Assurance Officer (PSAO)

Who is your PSAO ? ? ?

PSAO duties include:

POC for your area regarding Patient Safety concerns

POC for investigations regarding patient safety issues that pertain to his/her clinical area

POC to communicate solutions back to their area



Operating Room



Orthopedic Clinic



14CD



Pediatric Clinic



Pulmonary and Endocrinology Clinics



Family Practice Clinic



Department of Pathology and Laboratory Services



Department of Radiology

Many of the PSAOs are featured in the LRMC 2005 Patient Safety Calendar, pictured above, which highlights the National Patient Safety Goals.



Photo provided by Paula Acker, Health Systems Specialist, Patient Safety Office, LRMC
COL Kent Bradley, Chairman, LRMC Patient Safety Committee, briefs PSAOs.

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Education and marketing materials for the ASK ME! Campaign are available for all MHS facilities. Order forms for these materials may be accessed on the DoD Patient Safety website: <https://patientsafety.satx.disa.mil>. Please allow a minimum of two weeks for delivery. For more information, contact: Ms. Liza Fernandez: (703) 681-0064 or liza.fernandez@tma.osd.mil.

Project News Share

In the last issue of the Newsletter, we asked readers to observe Patient Safety Awareness Week by sharing newsletters published locally in our Military Treatment Facilities. Eleven newsletters were received, representing efforts by patient safety departments across the services. The newsletters run from one to four

pages, and are published monthly or quarterly. Most include short summaries from varied military and civilian resources, as well as articles of local interest and features spotlighting individuals for special contributions. JCAHO is the most frequently cited outside resource, with emphasis on the National Patient Safety Goals and survey issues. All facilities circulate their newsletters via email, and many distribute hard copies at safety meetings.

The list below cannot adequately convey the variety, energy and visual appeal of these local efforts. To all of you who participated in Project News Share, and to the many others who publish newsletters we haven't seen, we salute your good work! Here is some of the good news circulating in our DoD Military Healthcare System:

Patient Safety Digest	96th MDG, Eglin AFB
Patient Safety Matters	31st MDG, Aviano AFB
Patient Safety Newsletter	Dewitt Healthcare Network, Ft. Belvoir
Patient Safety Newsletter	Landstuhl Regional Medical Center
Patient Safety Quarterly News	Naval Hospital Lemoore
Patient Safety Update	355th MDG, Davis-Monthan AFB
Safety Zone	88th MDG, Wright-Patterson AFB
The Report	Womack Army Medical Center
ToothTales	Naval Dental Center Southeast

Patient Safety Awards

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the Composite Healthcare System (CHCS) to alert providers and pharmacy staff when the medication dose ordered for pediatric patients exceeds the maximum daily dose. Prior to this enhancement, the existing CHCS system was incapable of using documented weight to calculate and verify dosing appropriateness. Since a large number of pediatric prescriptions are for weight-dosed medications, the built-in CHCS MDD warning system was not universally helpful for the pediatric population. This improved functionality was made possible by linking available information on patient's weight with the existing capacity of the Composite Healthcare System (CHCS) to calculate maximum daily doses.

To initiate the MDD Project, the Pharmacy and Pediatrics departments collaborated to create an Average Weight Chart (AWC) based on patient age. A weight was assigned to each age range, making it possible to opti-

mize the CHCS dosage calculation function to verify dosing appropriateness for all pediatric weight-dosed medications. Finally, Pharmacy researched and determined the maximum daily dose for the most commonly ordered pediatric medications and programmed this field into CHCS. CHCS at USNHO now is capable of generating a real-time warning for the provider and pharmacy staff when the dose ordered is over the daily recommended dose based on the pediatric patient's weight.

The MDD Project, begun in February 2003 and completed in August 2004, has prevented overdoses, and has provided a rich field of data which Pharmacy reviews to identify trends and implement corrective actions. In undertaking the MDD Project, the Pharmacy at USNHO proactively set about to better align pharmacy practice with the hospital-wide goal of patient safety. The MDD Project can easily be duplicated and implemented in all facilities that employ CHCS.

For more information, contact hatv@oki10.med.navy.mil.

PATIENT SAFETY

Patient Safety is published by the Department of Defense (DoD) Patient Safety Center, located at the Armed Forces Institute of Pathology (AFIP). This quarterly bulletin provides periodic updates on the progress of the DoD Patient Safety Program.

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DoD PATIENT SAFETY WEBSITE

The DoD Patient Safety Website is now accessible at this address: <https://patientsafety.satx.disa.mil>. New content has been added. Particular attention is called to the FAQ section, where you will find answers to questions regarding MedTeams training and Monthly Summary Reports. Access past copies of the Patient Safety Bulletin, link to patient safety resources and contact the Patient Safety Program. Continue to review the website for the latest information on DoD training.